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1.0 Description of the Procedure

~~A short lingual frenulum creates a medical problem when it significantly restricts the range of tongue-tip mobility required for feeding, speech, maintenance of oral hygiene, or when it causes stripping of tissues lingual to lower anterior teeth. Surgery of the lingual frenulum relieves these conditions.~~ Surgery of the lingual frenulum includes incision, excision, or surgical alteration of a short frenulum (ankyloglossia, or tongue-tie, high frenulum attachment) in order to free the tongue and allow greater range of motion.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

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Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

c. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

d. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

~~Surgery of the lingual frenulum is covered for the following conditions:~~

~~a. The tongue-tip cannot move upward to the alveolar ridge or incisor teeth.~~

~~b. There is significant dysfunction in feeding, speech or in the maintenance of oral hygiene.~~

~~a. There is stripping of tissues lingual to lower anterior teeth.~~

3.1 General Criteria

Medicaid covers surgery of the lingual frenulum when it is medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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3.2 Specific Criteria

Surgery of the lingual frenulum is covered when:

a. there is evidence of recession in the gingival tissues adjacent to the lower anterior teeth,

OR

b. the tongue-tip cannot extend upward to the posterior alveolar ridge and/or molars, or the anterior alveolar ridge and/or incisors;

AND

c. there is significant dysfunction in feeding, speaking, or maintaining oral hygiene, as indicated by medical record or dental record documentation of one of the following:

1. the type of feeding difficulty, recipient's height and weight (when ankyloglossia treatment is indicated due to an impact upon growth), and the results of other treatment measures attempted; or
2. the severity of the articulation disorder, as determined by a formal speech/language evaluation; or
3. the oral hygiene issues involved, and the results of other treatment measures attempted.

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

~~Surgery of the lingual frenulum is not covered when the criteria listed in **Section 3.0** and guidelines in **Section 5.0** are not met.~~

4.1 General Criteria

Surgery of the lingual frenulum is not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure unnecessarily duplicates another provider's procedure;
d. the procedure is experimental, investigational, or part of a clinical trial; or
e. the guidelines in **Section 5.0** are not met.

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5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

~~Prior approval is required except as indicated below. The following information must be submitted with the prior approval request:~~

~~1. Medical documentation that the tongue-tip cannot move upward to the alveolar ridge or incisor teeth; or~~

~~2. Medical documentation that there is significant dysfunction in feeding, speech or in the maintenance of oral hygiene; or~~

~~3. Medical documentation that there is or will probably be stripping of tissues lingual to lower anterior teeth.~~

~~Prior approval is not required for recipients 30 days of age or younger when the claim contains diagnoses 750.0 and 779.3 for CPT codes 41010 or 41115.~~

5.1.1 Prior Approval for Recipients over 30 Days of Age

The following information must be submitted with the prior approval request:

a. Medical or dental record documentation that there is evidence of recession in the gingival tissues adjacent to the lower anterior teeth

OR

b. Medical or dental record documentation that the tongue-tip cannot extend upward to the posterior alveolar ridge and/or molars, or the anterior alveolar ridge and/or incisors; and, as outlined in **Section 3.0**, that there is significant dysfunction in feeding, speaking, or maintaining oral hygiene.

5.1.2 Prior Approval for Recipients 30 Days of Age or Younger

Prior approval is not required for recipients 30 days of age or younger

a. when the criteria in **Section 3.0** are met, the ICD-9-CM diagnosis codes 750.0 and 779.3 describe the condition of the infant,

AND

b. when the procedure to be performed is

1. incision of lingual frenulum (frenotomy), CPT 41010, D7963

OR

2. excision of lingual frenum (frenectomy), CPT 41115, D7960.

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5.2 Limitation

Surgery of the lingual frenulum is limited to once per lifetime.

6.0 Providers Eligible to Bill for the Procedure

Physicians or dentists enrolled in the N.C. Medicaid program who perform this surgery may bill for this service.

7.0 Additional Requirements

There are no additional requirements.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

8.1 Claim Form

Providers bill professional physician services on the CMS-1500 claim form.

8.2 Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

8.3 Procedure Codes

CPT and ADA codes ~~that are~~ covered by the Medicaid program include **41010**, **41115**, **41520**, **D7960, and D7963**.

Dental providers should refer to **Clinical Coverage Policy No. 4A, *Dental Services***, for the specific covered codes and billing guidelines.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

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9.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1974

Revision Information:

Date	Section Revised	Change
04/01/04	Sections 1.0, 3.0, and 5.0	Added "stripping of tissues lingual to lower anterior teeth"
04/01/04	Section 5.1	Exempted recipients ≤ 30 days of age from PA for 41010 or 41115 when 750.0 and 779.3 are on claim.
04/01/04	Section 6.0	Added dentists
9/01/05	Section 2.0	A special provision related to EPSDT was added.
12/01/05	Section 2.2	The web address for DMA's EPSDT policy instructions was added to this section.
11/1/06	Sections 2.0 through 5.0	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
	Section 3.1	General coverage criteria were added to the policy.
	Section 3.2	The specific coverage criteria were revised.
	Section 4.1	The general coverage criteria were revised.
	Section 5.0	Prior approval requirements were clarified.
	Section 8.3	Dental codes were added to the policy